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Office of Administrative Law Judges
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Issue date: 28Feb2002

CASE NO.: 2001-BLA-227

IN THE MATTER OF

OWEN C. BABB,
Claimant

v.

PETER FORK MINING CO.,
Employer

and

DIRECTOR, OFFICE OF WORKERS' COMPENSATION PROGRAMS,
Party-in-Interest

APPEARANCES:

Charles B. W. Palmer, Esq.,
For the Claimant

Lois A. Kitts, Esq.,
For the Employer

BEFORE: CLEMENT J. KENNINGTON
ADMINISTRATIVE LAW JUDGE

DECISION AND ORDER DENYING MODIFICATION

This is a claim for benefits under the Black Lung Benefits Act, 30 U.S.C. 901 *et. seq*. brought by the estate of Owen Babb (Claimant), against Peter Fork Mining Company (Employer), after the District Director denied Claimant's Request for Modification. By agreement of the parties, no formal hearing was held, but the parties were afforded the opportunity to submit briefs and exhibits in support of their positions.

Employer did not submit a brief. Based upon the evidence introduced and the arguments presented, I make the following Findings of Fact, Conclusions of Law, and Order.

I. Procedural History

On May 16, 1994, Administrative Law Judge Thomas denied Claimant benefits under the Act after a formal hearing. Claimant filed a Motion for Reconsideration which Judge Thomas denied on February 2, 1995. On February 10, 1995, Claimant appealed the decision to the Benefits Review Board, which, on June 11, 1996, affirmed Judge Thomas' denial. On June 28, 1996, Claimant filed another Request for Reconsideration which was denied by the Board on August 8, 1996. On October 6, 1996, Claimant filed a Notice of Appeal to the Fifth Circuit, a Request for Reconsideration, and a Request for Modification. The Request for Reconsideration apparently was not timely filed within thirty days of the Board's August 8, 1996 decision and the case was given back to the District Director to determine the modification issue. On June 9, 2000, the District Director denied Claimant's Request for Modification, and the Director's proposed decision and order was not served on Claimant's counsel until July 13, 2000. On August 9, 2000, Claimant's counsel requested a formal hearing, and in the alternative, Reconsideration, and this Request was received on August 14, 2000. The matter was then referred to the Office of Administrative Law Judges.

II. Statement of the Case

II (A) "Old Evidence"

On June 6, 1994, Administrative Law Judge Earl Thomas denied Black Lung Benefits to Claimant. (DR 48, p.1). In his decision, Judge Thomas noted the following background information:

> Claimant testified that he first worked in coal mine employment in 1976 and ended in 1984, for a total of eight years of surface coal mine work. He testified that during this time he worked as a blaster, and was responsible for loading 50 pound bags of explosives on a truck, unloading them at the drill site, placing the explosives in the drill holes and then setting them off. He stated that the explosives caused a large amount of rock dust. He explained that he was responsible for drilling the rock but that sometimes there was coal dust exposed when they reached the coal during the course of their blasting. He was responsible for sweeping the coal that became exposed. He further testified that prior to his coal mine work, he spent twenty years in the military where he performed the duties of as surveyor. He stated that after he concluded his military career, he was employed in the private sector as a surveyor for about eight years. During both of these stints as a surveyor, Claimant stated, he was exposed to large amounts of dust.

Claimant stated that he retired from coal mining because he could no longer perform the duties that he was required to do because of fatigue caused by shortness of breath. However, Claimant also testified that when he worked as a surveyor he also got short of breath if he was required to climb up an embankment. He also stated that he smoked cigarettes while employed as a coal miner. He stated that he smoked cigarettes for approximately 42 to 45 years at the rate of ½ to 3/4 packs of cigarettes per day, ending in 1988.

Babb v. Peter Fork Mining Co., 93-BLA-1209 (May 16, 1994)(ALJ).

ALJ Thomas also summarized and weighed the medical evidence as it existed prior to 1994:

On October 15, 1992, Dr. McCuller performed a pneumoconiosis examination and attached an occupational history. He noted that Claimant started smoking at the age of 14 and continued to smoke at the rate of 1 and ½ packs of cigarettes per day until the age of 67. However, Dr. McCuller amended the history of tobacco use by an addendum dated April 12, 1993. Therein, he states that Claimant contacted him to correct certain errors in his medical report. Claimant reported to Dr. McCuller that he began smoking at age 14 but only smoked a cigarette maybe once a week until he entered the service. At that time he began smoking 10-15 cigarettes per day which he continued to do until about 1985-1987. Dr. McCuller then stated "[b]eginning at that time, he began to smoke about a pack and a half a day. He recently stopped doing this." In his report Dr. McCuller stated that the physical examination of the chest revealed an increased AP diameter with slight hyperresonance and diminished breath sounds. He obtained a chest x-ray which he interpreted as ½ pneumoconiosis. A pulmonary function study showed moderate obstruction and moderate hyperinflation. He reported that an arterial blood-gas study produced normal values. Dr. McCuller diagnosed chronic obstructive pulmonary disease of moderate degree, probable emphysema, and simple coal workers pneumoconiosis. He attributed these diagnoses to prolonged tobacco use and possible contribution from exposure to coal dust. Dr. McCuller concluded that Claimant has sustained a moderate to severe degree of impairment, which will likely prevent further performance of his last coal-mine job.

On August 2, 1993, Dr. McCuller was deposed. He stated that he is Board certified in pulmonary medicine and in internal medicine. Dr. McCuller acknowledged that all of the abnormalities he noted as part of his examination of Claimant are most commonly associated with a long smoking history. He further stated that when he reviewed his x-ray, which he interpreted as showing ½ pneumoconiosis, the standard films for comparison were not available. He stated that someone with pneumoconiosis would not be expected to have an extensive obstructive defect and that it is his opinion that Claimant's cigarette

smoking as opposed to his coal mine employment causes his obstructive defect.

On May 7, 1993, Dr. Matt Vuskovich performed a pulmonary evaluation. He reported a coal mine occupational history of almost eight years, and a cigarette smoking habit beginning at age 19 at the rate of one pack per day, and ending five years ago, for a total of a 35-pack year smoking history. Dr. Vuskovich stated that examination of the chest revealed breath sounds to be distant with increased dorsal kyphosis of the thoracic cage, wheezing throughout both lung fields with deep inspiration and forced expiration. He stated that pulmonary function studies showed moderate obstructive impairment with FEV1 value of 1.53 representing 49% of the predicted, and the MVV value of 63 representing 55% of predicted. He interpreted a film taken that day as category 0/0. Dr. Vuskovich diagnosed chronic obstructive emphysema and moderate obstructive impairment, secondary thereto. He stated that there is no objective evidence to make a diagnosis of coal worker's pneumoconiosis or silicosis, and that 100% of his impairment could be apportioned to chronic obstructive pulmonary disease related to cigarette abuse. He did conclude that from a pulmonary standpoint, Claimant would probably have difficulty returning to work in the coal mine industry because of his chronic obstructive pulmonary disease, secondary to cigarette abuse.

On June 21, 1993, Dr. Vuskovich was deposed and stated that he specializes in occupational medicine and is Board eligible in emergency medicine as well as certified as a B-Reader. Dr. Vuskovich explained that the pulmonary function study produced an FVC that was 85% of predicted and this ruled out a restrictive problem. He further stated that there are enough factors in this case to distinguish between pulmonary impairment caused by smoking and impairment caused by the inhalation of dust and/or coal worker's pneumoconiosis. He stated that in this case Claimant has a 35-pack-year of cigarette smoking and no evidence of even simple coal worker's pneumoconiosis.

In a report dated August 3, 1993, Dr. Emery Lane, Board certified in internal medicine and a certified B-Reader, analyzed the medical evidence he reviewed in connection with this case, which is detailed therein. Dr. Lane concluded that there is no evidence that Claimant has an impairment arising from coal mine employment and that Claimant does not have the respiratory ability to perform the work of an underground coal miner because he has moderately advanced chronic obstructive pulmonary disease. He stated further that it is possible to distinguish between Claimant's pulmonary disability caused by cigarette smoking as opposed to coal mine dust based on medical evidence. He stated that Claimant has a moderate obstructive defect on pulmonary function testing, which is related to cigarette smoking, and does not have a restrictive abnormality which is caused by exposure to coal mine dust.

In a letter dated August 11, 1993, Dr. Michael P. McCarthy stated that he

performed a history and physical on Claimant that same day and also reviewed medical records consisting of chest x-rays, pulmonary function tests and arterial blood gases. Without providing any details on this examination or on the evidence he reviewed, Dr. McCarthty stated that Claimant has evidence of chronic obstructive lung disease of moderate to moderately severe degree. He concluded that this most likely represents emphysema but that Claimant also has a history and clinical findings of coal worker's pneumoconiosis. He further noted that Claimant has a long history of tobacco abuse and an eight year history of exposure to coal dust. He stated that it is impossible to decide conclusively on the respective roles of these competing exposures in the development of Claimant's condition but that coal dust exposure did make a minor contribution, and was an aggravating factor.

As agreed at the hearing, a deposition of McCarthy was taken on March 9, 1994, and is hereby admitted into evidence. Dr. McCarthy stated that he is a pulmonary specialist and is Board eligible for the certification process in that sub-speciality. He stated that Claimant had somewhere near thirty to forty pack years of smoking cigarettes, ending in 1988, and that this history in and of itself is sufficient to cause a significant pulmonary or respiratory impairment. He further stated that on review of all the date he received, he could not state for certainty that Claimant has coal workers' pneumoconiosis. However, Dr. McCarthy also testified that the pulmonary function study taken on August 5, 1993 showed a mild reduction in his vital capacity which could be associated with a mild, very mild, restricted ventilatory defect. He stated that he could not make the call as to whether or not coal dust exposure played any part in Claimant's pulmonary impairment, and if it did contribute, to what extent.

On August 22, 1993, Dr. William H. Anderson, Board certified in pulmonary disease and in internal medicine, reported that he reviewed seven x-ray readings, two pulmonary function studies, and two arterial blood gas tests, as described in his attached sheet. He stated that the preponderance of the evidence shows that Claimant does not have pneumoconiosis, that he has an obstructive air way disease of the type seen as a consequence of cigarette smoking, and he has a normal gas exchange. Dr. Anderson concluded, with a high degree of medical certainty, that the impairment is not due to pneumoconiosis, but to cigarette smoking.

In a report dated October 5, 1993, Dr. Gregory J. Fino, Board certified in pulmonary disease and internal medicine and a certified B-reader, detailed the evidence he reviewed in regard to this case. In regard to the positive x-ray findings by Drs. McCuller and Moony, Dr. Fino stated that their findings of irregular opacities is inconsistent with coal worker's pneumoconiosis. He stated that abnormalities caused by the inhalation of coal mine dust show are evidenced (sic) by rounded opacities appearing first in the upper portion of the right lung, and then progressing, in descending order, to the

left upper zone, then the two middle zones, and finally the two lower zones. He added that opacities found only in the lower lung zones only do not indicate a coal dust related lung condition. Dr. Moony's x-ray report noted primarily irregular opacities in the two lowest sections. Dr. McCuller found evidence of largely irregular opacities in the bottom four sections. Dr. Fino concluded, after extensive review of the evidence, that Claimant does not suffer from an occupationally acquired pulmonary condition as a result of coal mine dust exposure. He based this conclusion on the fact that the majority of the chest x-ray readings are negative from pneumoconiosis and the spirometric evaluations show a pure obstructive ventilatory abnormality with no evidence of any restrictive defect. Furthermore, he added, the stats show more involvement in the small airways than in the large airways which is not consistent with a coal dust related condition but is consistent with conditions such as cigarette smoking, pulmonary emphysema, chronic bronchitis, and asthma. He also found that Claimant has significant anatomical emphysema based on the reduction in the diffusing capacity. For these reasons, Dr. Fino concluded that he is able to distinguish between the pulmonary disability caused by smoking and that due to coal mine dust exposure. He therefore reasoned that Claimant was disabled due to his cigarette smoking history and would be as disabled if he had never worked in the mining industry.

In a report dated December 1, 1993, Dr. D.L. Rasmussen, Board certified in internal medicine, detailed the evidence he reviewed. He stated in his report that Claimant's history of eight years of coal mine employment is sufficient for contracting silicosis in a susceptible individual. Dr. Rasmussen noted that the x-ray interpretations were mixed in regard to diagnosing pneumoconiosis. He also contested the opinions of Drs. Anderson, Fino, Lane and Vuskovich that coal mine dust exposure solely causes a restrictive disease. He stated that there is growing evidence that chronic obstructive lung disease may be the consequence of coal mine dust exposure including exposure to silicon dioxide and cited an (sic) number of medical articles in support thereof. He stated that while Claimant had a significant cigarette smoking history, which could lead to severe chronic obstructive lung disease, he also had exposure to significant silicon dioxide, which can also cause chronic obstructive lung disease, and that it must be concluded that Claimant's coal mine dust exposure was a clearly significant contributing factor to his disabling respiratory insufficiency.

Dr. Rasmussen then examined Claimant on December 28, 1993. He requested the x-ray interpretation from Dr. Bassali which was reported as showing category ½ pneumoconiosis in all lung with both regular and irregular opacities. Dr. Rasmussen obtained a pulmonary function study which he stated revealed severe, partially reversible obstructive ventilatory impairment, and a maximum breathing capacity which was moderately reduced. He stated that Claimant's pulmonary impairment would render him totally disabled for any significant gainful employment and obviously accounts for his severe effort dyspnea. He described Claimant's occupational history and described his coal mine

blasting experience as exposing him to heavy dust that would take him ½ hour to clear out of his nose and mouth when he returned home. Dr. Rasmussen reported a smoking history that began at the rate of ½ to 3/4 packs of cigarettes per day until quitting in 1988. Dr. Rasmussen concluded that Claimant has a significant history of exposure to occupational dusts including 8 years of intense exposure to silicon dioxide while employed as a blaster in surface coal mining. He stated that Claimant has x-ray changes which are consistent with pneumoconiosis. He stated that it is medically reasonable to conclude that Claimant has occupational pneumoconiosis, i.e., silicosis, which arose as a consequence of his occupational exposure. Dr. Rasmussen acknowledges that Claimant has two obvious risk factors for his disabling respiratory insufficiency, i.e., his cigarette smoking and his coal mine dust exposure. However, he stated, his coal mine dust exposure must be considered a major contributing factor to his totally disabling respiratory insufficiency.

In summary, Drs. Fino, Anderson, Vuskovich and Lane found no evidence of pneumoconiosis and attributed all of Claimant's pulmonary disability to his extensive history of cigarette smoking. Dr. McCarthy diagnosed pneumoconiosis by x-ray but in his deposition appeared to hesitate in affirming that diagnosis and acknowledged that he did not have the standard films for comparison when evaluating the x-ray. Dr. McCarthy also stated in his report that Claimant had clinical findings of pneumoconiosis, but at his deposition concluded that he could not state for certainty that Claimant had coal worker's pneumoconiosis. Thus, the only physician who concluded with any degree of certainty that Claimant has pneumoconiosis is Dr. Rasmussen. In light of the fact that the majority of the physicians that examined Claimant, and/or reviewed medical records, concluded that there was insufficient evidence to support a diagnosis of pneumoconiosis, I find that Claimant has failed to establish the presence of pneumoconiosis. In particular, Dr. Fino, a highly qualified pulmonary specialist, provided a detailed rationale as to why the x-ray evidence and the pulmonary function studies indicated that Claimant did not have pneumoconiosis. Drs. Anderson, Vuskovich and Lane also presented strong rationales for their findings and their opinions are well documented. Dr. Rasmussen is also highly qualified and presented a well reasoned and documented opinion. However, he reports a significantly lower history of cigarette smoking than any other physician of record. He states that Claimant smoked up to 3/4 packs per day while Dr. McCuller and Vuskovich reported 1 to 1 and ½ packs per day for over forty years. He also infers in his opinion that Claimant was continuously exposed to coal mine dust during the course of his employment as a blaster in a surface coal mine operation but Claimant's own testimony indicates that he as primarily exposed to rock dust. For these reasons, I find that his opinion is outweighed by the opinions of Drs. Fino, Anderson, Vuskovich and Lane. Claimant therefore failed to establish the presence of pneumoconiosis by any means provided in the regulations. He is therefore not entitled to benefits under the Act.

Babb v. Peter Fork Mining Co., 93-BLA-1209 (ALJ May 16, 1994)(record citations omitted).

Following Judge Thomas' decision, Claimant filed a Motion for Reconsideration, arguing in part that judge Thomas erred in: giving more weight to Employer's physicians based on numerical superiority; attributing an incorrect smoking history to Claimant after Claimant had corrected the mistake made by Drs. McCuller and Vuskovich, and which mistake of fact was picked up by the other reviewing doctors; and in discounting Dr. Rasmussen's opinion because Dr. Rasmussen used a lower smoking history than the other physicians of record. (DX 50). On February 2, 1995, Judge Thomas denied the Motion for Reconsideration stating that no "mistake of fact or law was made." (DX 52).

On February 10, 1995, Claimant appealed the decision to the Benefits Review Board. (DX 52). On May 22 & 28, 1996, Claimant applied to the Board for Reconsideration. (DX 63). On June 11, 1996, The Board issued an opinion that affirmed Judge Thomas' decision. (DX 58; DX 59). Specifically, the Board determined that smoking and employment histories were irrelevant to x-ray findings showing no evidence of pneumoconiosis, and to the extent that the ALJ relied on the x-ray evidence Claimant's argument was without merit. (DX 58, p. 2). The Board did determine that the ALJ erred in discounting Dr. Rasmussen's opinion based on an incorrect smoking history, but, found such error harmless as the ALJ had relied on the "strong rationales" for not finding pneumoconiosis in the medical reports of Drs. Anderson, Fino, Lane and Vuskovich. *Id*. at 3-4. Claimant filed another Motion for Reconsideration on June 28, 1996. (DX 63). On August 8, 1996, the Board denied Claimant's Motion for Reconsideration. (DX 62). On October 6, 1996, Claimant filed a notice of appeal to the Fifth Circuit, and/or a Request for Reconsideration and a Request for Modification. (DX 63). Claimant stated in the omnibus motion that because his appellate delays tolled on October 8, 1996, he desired to appeal to preserve his right, but "to delay further action on his appeal until the disposition of the application for modification, i.e. claimant is appealing, but delaying same, until his right to seek to modify the court decree are (sic) disposed of." *Id*.

On September 15, 1997, Claimant's counsel was contacted by the District Director to provide the additional evidence to support modification after the Director received the filed from the Board. (DX 69). Claimant submitted a brief in response relating that the new evidence was incorporated in the old record. *Id*. In essence, Claimant contended that the record "showed that '<u>old evidence</u>,' cast in a '<u>new light</u>' was, in fact, '<u>new evidence</u>.'" *Id*. (emphasis in original). Namely, Claimant contended that the physicians relied upon by Judge Thomas to deny benefits had relied on an incorrect smoking history. *Id*. On June 9, 2000, the District Director set forth findings of fact and proposed to deny benefits. *Id*. On August 14, 2000, Claimant filed a motion for a hearing, or alternatively, reconsideration after the district director proposed that Claimant's request for modification be denied. (DR 69).

II (B) "New Evidence"

B (1) Dr. McCuller

On April 13, 1993, Dr. McCuller issued an addendum to the medical record correcting certain

mistakes of fact stemming from his interview with Claimant. (CX 20). Specifically, Dr. McCuller noted that Claimant smoking history was such that:

> He began smoking at age 14, smoking a cigarette maybe once a week until he entered the service. At that time he began to smoke about 10-15 cigarettes per day which he continued to do until about 1985-1987. Beginning at that time he began to smoke about a pack and a half a day. He recently stopped doing this.

(CX 20).

B (2) Dr. Repsher's Medical Report

On April 10, 2001, Dr. Repsher issued a report to Employer after reviewing two x-ray films from 1993 and various medical records. (EX 9, p.1). Dr. Repsher noted a smoking history of 1 ½ packs of cigarettes a day from the age of fourteen to sixty-seven, with Claimant quitting in 1988 due to shortness of breath. *Id*. A March 4, 1993 x-ray film was unreadable and the second film, dated December 28, 1993, was also of poor quality with Dr. Repsher rating the film a "3." *Id*. at 2. Nonetheless, based on the December 28, 1993 film, Dr. Repsher detected increased bronchovascular markings suggesting a history of cigarette smoking. *Id*.

Concerning Claimant's pulmonary function tests and arterial blood-gas studies, Dr. Repsher noted a problem with cooperation, but stated that Claimant clearly suffered from COPD. *Id*. Specifically, there was no evidence of a restrictive blockage and the diffusing capacity was markedly decreased suggesting severe centrilobular emphysema. *Id*. While the blood-gas study was normal at rest, there was a significant decrease in arterial PO_2 with exercise which met DOL standards for total disability. *Id*. In addition to COPD, Dr. Repsher diagnosed Grave's disease, and a history of "pernicious anemia." *Id*. at 3. Dr. Repsher concluded that Claimant never suffered from pneumoconiosis or any other respiratory or pulmonary disease caused or aggravated by coal mine employment because: there was no x-ray evidence of pneumoconiosis, pulmonary function evidence was negative for pneumoconiosis as Claimant's airways were obstructed and not restricted, and the arterial blood-gas abnormalities were consistent with his underlying moderately severe COPD and emphysema. *Id*. at 4.

Regarding Claimant's death, Dr. Repsher opined that it was due to a severe exacerbation of underlying COPD as a result of a deep pulmonary infection or as a result of an acute myocardial infarction, as a result of an underlying arteriosclerotic heart disease which was aggravated by Claimant's long smoking history. *Id*. Furthermore, even if Claimant did have histologic evidence of pneumoconiosis it would only involve a small part of the lung parenchyma and would not have a measurable effect on his pulmonary function. *Id*.

B (3) Dr. Fino's Medical Report

On April 17, 2001, Dr. Fino issued a report to Employer reaffirming his earlier opinion of October 5, 1993, that Claimant did not have pneumoconiosis, after reviewing new medical evidence. (EX 9, p. 1, 11). Dr. Fino did state that Claimant died from a disabling respiratory impairment, but did not find that Claimant's impairment was due to his coal mine employment. *Id*. at 9. Dr. Fino reached this conclusion because Claimant's death certificate lists an evolving heart attack, and heart attacks are due to coronary artery disease, which is unrelated to coal mine dust inhalation. *Id*. Rather, Claimant's respiratory impairment was due to smoking and there was no evidence that his coal dust inhalation was of any discernable consequence to his respiratory disability

B (4) Deposition of Dr. Fino

Employer noticed the deposition of Dr. Fino on May 31, 2001. (Fino. dep. p. 1). Dr. Fino admitted that an eight year exposure to coal mine dust could cause pneumoconiosis, but such a limited period of time would not likely be sufficient to cause damage due to coal dust inhalation. *Id*. at 5. Nonetheless, Dr. Fino assumed that Claimant's exposure time was sufficient to develop pneumoconiosis and evaluated the medical evidence based on an assumption that Claimant received adequate exposure to suffer from pneumoconiosis. *Id*. at 5-6.

When viewing the film of Claimant's chest taken on 12-28-93, Dr. Fino stated that he looked for rounded opacities of the P, Q, or R variety beginning in the upper lung zones in a profusion of at least 1/0 to make a finding of pneumoconiosis. *Id*. at 7. Admitting that Claimant had obstructive lung impairments, Dr. Fino stated that under the right circumstances, with enough coal dust exposure, a coal worker could have pneumoconiosis that would obstruct rather than restrict the airways. *Id*. at 8-9. Considering Claimant's eight year exposure, however, Dr. Fino did not believe Claimant could have developed such an obstructive impairment from coal dust. *Id*. Rather, Claimant's obstruction was due to smoking. *Id*. at 8. Even taking the lowest history of cigarette smoking in the record, such a change in smoking history would not change his opinion that smoking was cause of Claimant's pulmonary impairment because even the lowest smoking history was enough to cause chronic obstructive bronchitis or emphysema. *Id*. at 10, 19-20.

Dr. Fino further stated that Claimant's exposure to coal dust did not have any discernable consequence to Claimant's pulmonary impairment and that pneumoconiosis did not in any way cause or hasten Claimant's death. *Id*. Likewise, while Dr. Fino was not aware of Dr. McCuller's retraction regarding Claimant's smoking history in 1993, such a retraction would not have changed Dr. Fino's medical conclusions in 1993 that Claimant did not have pneumoconiosis. *Id*. at 19-20.

B (5) Deposition of Dr. Wiot

Employer noticed the deposition of Dr. Wiot on May 23, 2001. (Wiot Dep. p. 3). Dr. Wiot

related that a physician who views several x-ray films is in the best position to make an accurate determination of whether the film is normal or abnormal because what one may be looking for is so minor that it may not be recognizable on a single film. *Id*. at 16. Similarly, film quality is very important because a dark film can appear normal and a light film can lead the reader into thinking a disease exists that is not really there. *Id*. at 17. In rating the quality of films, quality "one" is the best, but quality "two" and "three" are still acceptable for recognizing the minimal changes of occupational pulmonary disease. *Id*. at 25.

Coal workers' pneumoconiosis is manifested radiographically by small round opacities usually occurring in the right upper lung fields moving down the chest rather than up. *Id*. at 18-19. Complicated coal workers' pneumoconiosis is evinced by large opacities in the upper lung fields, and is associated with enlarged air sacs. *Id*. at 19. When he reviewed Claimant's chest x-ray, Dr. Wiot did not have Claimant's smoking history, and stated that he did not like to have such information when he reviewed the x-rays. *Id*. Likewise, Dr. Wiot does not obtain a coal dust exposure history, but he automatically assumes that the patient had an adequate exposure time. *Id*. at 27-28. Dr. Wiot further stated that in close cases he always gave the benefit of the doubt to the patient in finding coal workers' pneumoconiosis.[1] *Id*. at 21. Viewing

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[1] Contrary to Dr. Wiot's statement, I have not found this to be the case in contested Circuit Court cases. *See e.g*, *Dingess v. Peabody Coal Co.*, 194 F.3d 1304, 1999 WL 760252 (4th Cir. 1999)(Table)(finding that Dr. Wiot was one of eighteen readers interpreting an x-ray as negative when three other readers interpreted it as positive); *Arch of KY., Inc v. Hickman*, 188 F.3d 506, 1999 WL 646283 (6th Cir. 1999)(Table)(issuing a medical report negating the existence of pneumoconiosis in a case containing thirty-nine interpretations of x-ray evidence, nine of which were positive); *Toliver v. P.G.&H., Inc.*, 172 F.3d 864, 1999 WL 30896 (4th Cir. 1999)(Table)(finding that Claimant's counsel properly objected to the admissibility of x-ray rereading by Dr. Wiot); *Copley v. Arch of WVA, Inc.*, 135 F.3d 769 1998 WL 62602 (4th Cir. 1998)(Table)(crediting the interpretation of Dr. Wiot in determining that the x-ray evidence did not prove the existence of pneumoconiosis); *Staton v. Norfolk & Western Ry. Co.*, 65 F.3d 55 (6th Cir. 1995)(finding that of eight readers, only Drs. Wiot and Spitz determined that the film was completely negative); *Adkins v. Arch of WVA, Inc.*, 61 F.3d 899, 1995 WL 432403 (4th Cir. 1995)(Table)(finding that Dr. Wiot rendered a negative interpretation of an x-ray when two other physicians interpreted it as positive); *Wiley v. Consolidation Coal Co.*, 39 F.3d 1183, 1994 WL 592836 (6th Cir. 1994)(Table)(stating that Dr. Wiot gave one of two negative interpretations when three other physicians interpreted the x-ray as positive); *Journell v. Southern Appalachian Coal Co.*, 23 F.3d 401, 1994 WL 191634 (4th Cir. 1994)(Table)(stating that Dr. Wiot gave one of three negative readings when two other physicians gave positive readings); *Fox v. Director, OWCP*, 991 F.2d 789, 1993 WL 104306 (4th Cir. 1993)(Table)(relying on a negative interpretation of an x-ray read solely by Drs. Wiot, Spitz and Shipley to determine that the x-ray evidence did not show pneumoconiosis when earlier x-rays were interpreted as positive); *Walker v. GAF Corp.*, 885 F.2d 872, 1989 WL 109754 (6th Cir. 1989)(Table)(interpreting an x-ray as not showing asbestosis when there was medical evidence to the contrary); *Everly v. Peabody Coal Co.*, 848 F.2d 190, 1988 WL 40480 (6th Cir. 1988)(Table)(finding Dr. Wiot gave one of two negative

the 10/15/92 film, Dr. Wiot identified bullae within the upper lung field. *Id*. at 26-27. Bullae is the breakdown in the normal lung tissue, and it is a form of emphysema related to smoking. *Id*. at 27.

B (6) Deposition of Dr. Rasmussen

Claimant noticed the deposition of Dr. Rasmussen on January 7, 2002. (CX 30, p.1). Since his 1993 medical report, Dr. Rasmussen had earned Board certification in forensic medicine, had become a B-reader and a senior disability analyst. *Id*. at 6. Dr. Rasmussen stated that Claimant's cigarette smoking caused some degree of impairment, but Dr. Rasmussen also concluded that eight years of exposure to coal mine dust was a contributing factor. *Id*. at 12.

Regarding the film taken on 12/28/93, interpreted by Dr. Bassali as ½, or positive for pneumoconiosis, Dr. Rasmussen stated that the small opacities shown on the film were quite consistent with either pneumoconiosis or silicosis and such evidence would not be created by the use of cigarettes. *Id*. at 20. Regarding his blood-gas study, Dr. Rasmussen explained that Claimant demonstrated a marked degree of hypoxia. *Id*. at 24. Dr. Rasmussen also explained the bronchodilator spirometry graph and explained that it indicated severe, partially reversible obstructive ventilatory impairment. *Id*. at 28.

III Discussion.

Contested issues by the parties include the timeliness of the modification request, the timeliness of the request for a formal hearing, and whether the evidence established a change in conditions and/or that a mistake was made in the determination of any fact in the prior denial per 20 C.F.R. § 725.310.

III (A) Timeliness of Modification Request

A claimant may seek modification "at any time before one year from the date . . . after the denial

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interpretations when a third reader interpreted the film as positive) ; *Creech v. Benefits Review Bd.*, 841 F.2d 706 (6th Cir. 1988)(finding film quality unreadable when another physician rendered a positive interpretation); *Prater v. Hite Preparation Co.*, 829 F.2d 1363 (6th Cir. 1987)(relating that Drs. Wiot and Spitz rendered negative interpretations when other physicians found evidence of pneumoconiosis); *Frost v. Benefits Review Bd.*, 821 F.2d 649, 1987 WL 37851 (6th Cir. 1987)(Table)(finding no evidence of disk atelectasis when an earlier physician had determined that there were "U" shaped irregularities in the lower lung zones); *C.f. Sexton v. Switch Energy Coal Corp.*, - - F.3d - -, 2001 WL 1136086 (6th Cir. 2001)(Table)(attributing large opacities in lung to pneumoconiosis and also noting old tuberculosis); *England v. Director, OWCP*, 120 F.3d 260, 1997 WL 419328 (4th Cir. 1997)(Table)(conceding that a 1989 x-ray showed complicated pneumoconiosis when arguing that the onset date of total disability should be 1989, not 1986, the date the claim was filed).

of a claim." 20 C.F.R. § 725.310 (2001). The period for seeking a modification of a prior decision begins to run when the decision is filed with the District Director. *Wooten v. Eastern Assoc. Coal Corp.*, 20 BLR 1-20 (1996). A denial of a previously filed motion for modification constitutes a "rejection of a claim" commencing a new statute of limitations for filing a motion for modification. *Betty B Coal Co. v. Director, OWCP*, 194 F.3d 491, 497 (4th Cir. 1999). *C.f. Webb Dean v. H. W. McLeod*, 270 So.2d 726, 728 (Fla. 1973)(stating that a "petition for modification cannot act to toll the limitation period for subsequent petitions for modification of an original order of compensation or a denial of an original claim for compensation."). If a claim is denied then the time period begins to run once the decision becomes final, thus, modification may be requested one year after the conclusion of the appellate process. *Moore v. Virginia International Terminals Inc.*, 35 BRBS 28, 30 (2001), citing *Black v. Bethlehem Steel Corp.*, 16 BRBS 138, 142 n.7 (1984). A request for modification need not be formal in nature, but it must be a writing which indicates an intention to seek further compensation. *Fireman's Fund Insurance Co. v. Bergeron*, 493 F.2d 545, 547 (5th Cir. 1974); *Madrid v. Coast Marine Construction Co.*, 22 BRBS 148, 151 (1989).

Here, Judge Thomas issued his decision on May 16, 1994. Claimant timely filed a Request for Reconsideration and timely filed an appeal to the Board within thirty days after Judge Thomas denied Reconsideration. See 20 C.F.R. § 725.479 (2001). On June 11, 1996, the Board affirmed Judge Thomas' decision denying benefits. Claimant timely filed a Request for Reconsideration, which was denied by the Board on August 8, 1996, and Claimant filed Notice of Appeal to the Fifth Circuit and/or a Request for Reconsideration and Modification on October 8, 1996. Although the filing of Appeal to the Fifth Circuit was accomplished within sixty days as required by 20 C.F.R. § 802.406 (2001), apparently Claimant's Request for Reconsideration did not fall within the thirty day time limitation. 20 C.F.R. § 802.407 (2001). Pursuant to Claimant's Request for Modification, which has a one year prescriptive period, the Board sent the record to the District Director who proposed to deny benefits on June 9, 2000. On August 9, 2000, Claimant mailed a Request for a Hearing, or alternatively Reconsideration of the District Director's proposed decision.

Accordingly, after Judge Thomas denied Claimant's Request for Reconsideration on February 2, 1995, Claimant timely appealed the matter to the Board keeping Judge Thomas' decision from becoming final. The Board's decision affirming Judge Thomas was issued on June 28, 1996, and Reconsideration denied on August 8, 1996. Claimant's Request for Modification, dated October 6, 1996, clearly fell within the one-year prescriptive period and is timely.

III (B) Timeliness of Request for a Formal Hearing

Ordinarily, a party has thirty days to request a formal hearing from the date of issuance of the district Director's proposed decision and order. 20 C.F.R. § 725.419(a) (2001). Under 29 C.F.R. § 18.4(b) (2001), of the Rules of Practice and Procedure for Administrative Hearings before the Office of Administrative Law Judges, the date of an entry of an order is the date the order is served by the Chief Docket Clerk. Thus, the date of "issuance" in 20 C.F.R. § 725.419(a) means the date of service on the

parties. *See Nealon v. California Stevedores & Balast Co.*, 996 F.2d 966, 970-71 (9th Cir. 1993)(requiring service before the time for taking an appeal begins to run); *Patton v. Director OWCP*, 763, F.2d 553, 556 (3rd Cir. 1985)(stating that proper service is an essential part of the filing process); 30 U.S.C. § 932(a) (2001) (adopting portions of the Longshore Act "except as otherwise provided . . . by regulations of the Secretary"). Documents are not deemed filed until received by the Office of Administrative Law Judges, "[h]owever, when documents are filed by mail, five (5) days shall be added to the prescriptive period." 29 C.F.R. § 18.4(c) (2001).

Here, Claimant asserts that he was not served with the Director's proposed decision and order until July 13, 2000, more than thirty days from when the District Director rendered his decision. Accordingly, Claimant's prescriptive period for filing a Request for a formal hearing began to run from that date. Claimant mailed his request on August 9, 2000, and it was received on August 14, 2000, within the thirty day prescriptive period as required by § 725.419 with an additional five days allowed for mailing. Therefore, Claimant's request for a formal hearing is timely.

III (C) Change in Conditions and/or Mistake-in-Fact.

Claimant alleges that the physicians who examined his records used an improper smoking history, and that Employer failed to send a corrected version to the examining physicians after Dr. McCuller issued an addendum that reduced his cigarette intake to no more than ten to fifteen cigarettes a day. Claimant contends that if Dr. McCuller's retracted findings of an excessive smoking history were sent to the other examining physicians in the record then those physicians would have determined that Claimant's pulmonary impairment, and eventual death, was due to pneumoconiosis and not smoking. A claimant seeking modification must prove either:

> (1) a change in conditions which requires a showing of a change in the miner's physical condition; or
> (2) a mistake in a determination of fact which can include an allegation that the ultimate fact, total disability due to pneumoconiosis, was wrongly decided.

See 20 C.F.R. § 725.310 (2001); *Consolidation Coal Co. v. Director, OWCP*, 27 F.3d 227, 229-30 (6th Cir. 1994); *Jesse v. Director, OWCP*, 5 F.3d 723, 724 (4th Cir. 1993); *Amax Coal Co. v. Franklin*, 957 F.2d 355, 356-57 (7th Cir. 1992); *Director, OWCP v. Drummond Coal Co.*, 831 F.2d 240, 244 (11th Cir. 1987).

In deciding whether the Claimant has established a change in conditions, I must "perform an independent assessment of the newly submitted evidence, in conjunction with evidence previously submitted, to determine if the weight of the new evidence is sufficient to establish the element or elements which defeated entitlement . . . ." *Napier v. Director, OWCP*, 17 BLR 1-111, 1-113 (1993). *See also Nataloni v. Director, OWCP*, 17 BLR 1-82, 1-84 (1993). A modification based on mistake-in-fact, however, requires no new evidence. *Nataloni*, 17 BLR at 1-84; *Kovac v. BCNR Mining Corp.*, 14 BLR

1-156, 1-158 (1990), *aff'd on recon*. 16 BLR 1-71, 1-73 (1992). *See also O'Keefe v. Aerojet-General Shipyards*, 404 U.S. 254, 256, 92 S. Ct. 404, 30 L. Ed. 2d 424 (1971). The fact-finder has "broad discretion to correct mistakes of fact, whether demonstrated by wholly new evidence, cumulative evidence, or merely further reflection on the evidence initially submitted." *Id*.

Even correcting Claimant's smoking history in the reports sent to the Employer's physicians, however, would not change the opinion of those physicians. Dr. Fino, in his May 31, 2001 deposition, stated that even taking considering this lower smoking history would not change his opinion because even the lowest history was enough to cause chronic obstructive bronchitis or emphysema. (Fino Dep. p. 10, 19-20). Similarly, Dr. Wiot, who reviewed Claimant's x-rays as negative for pneumoconiosis, stated that he never considers a patient's smoking history when examining the x-rays because he liked to view the x-ray evidence without outside influences.[2] (Wiot Dep. p. 27).

Claimant deposed Dr. Rasmussen on January 7, 2002. (CX 30, p. 1). Since his 1993 medical report, in which Dr. Rasmussen reported a correct smoking history, he had earned Board certification in forensic medicine, had become a B-reader and a senior disability analyst. *Id*. at 6. Dr. Rasmussen stated that Claimant's cigarette smoking caused some degree of impairment, but Dr. Rasmussen also concluded that eight years of exposure to coal mine dust was also a contributing factor. *Id*. at 12.

Regarding the film taken on 12/28/93, interpreted by Dr. Bassali as ½, or positive for pneumoconiosis, Dr. Rasmussen stated that the small opacities shown on the film were quite consistent with either pneumoconiosis or silicosis and such evidence would not be created by the use of cigarettes. *Id*. at 20. Regarding his blood-gas study, Dr. Rasmussen explained that Claimant demonstrated a marked degree of hypoxia. *Id*. at 24. Dr. Rasmussen also explained the bronchodilator spirometry graph and explained that it indicated severe, partially reversible obstructive ventilatory impairment. *Id*. at 28.

Accordingly, the only thing that is different today than from when Judge Thomas issued a decision in 1994 is the fact that Dr. Rasmussen became a more highly qualified expert in that he is now a B-reader.[3] Otherwise the grounds of Judge Thomas' original decision remain unchanged. Judge Thomas credited the "strong rationales" of Dr. Fino, Anderson, Vuskovick, and Lane over that of Dr. Rasmussen. Also, Judge Thomas discredited the opinion of Dr. Rasmussen on the basis that he inferred "that Claimant was continuously exposed to coal mine dust during the course of his employment as a blaster in a surface mine

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[2] On April 10, 2001, Dr. Repsher issued a report but he noted an incorrect smoking history of 1 ½ packs of cigarettes a day from the age of fourteen to sixty-seven. Thus, Dr. Repsher's opinion is entitled to less weight because it is unclear whether he would have reached the same conclusion based on a correct smoking history.

[3] Inexplicably, no autopsy was performed after Claimant's death.

operation but Claimant's own testimony indicat[ed] that he was primarily exposed to rock dust."[4] *Babb*, 93-BLA-1209 (ALJ May 16, 1994).

Furthermore, Judge Thomas was clearly aware of Dr. McCuller's addendum to Claimant's smoking history as it was expressly incorporated within his decision. Also, the issue was exhaustively briefed by Claimant before the Board in 1995, and the Board found Claimant's arguments without merit "[i]nasmuch as the physicians credited by the administrative law judge stated their x-ray readings according to the ILO classification, *see* 20 C.F.R. § 718.102(b), and smoking and employment histories are irrelevant to x-ray findings, claimant's argument is without merit."[5] *Babb*, 95-BLA-1047 (BRB May 22, 1996). The Board specifically upheld Judge Thomas stating:

> [T]he administrative law judge permissibly relied on the more numerous well-reasoned and well-documented medical opinions by Drs. Anderson, Fino, Lane and Vuskovich, diagnosing the absence of pneumoconiosis. The administrative law judge stated that these physicians provided "strong rationales" for their conclusions and in light of that, Dr. Rasmussen's opinion was insufficient to carry claimant's burden of proof.

Babb, 95-BLA-1047 (BRB May 22, 1996).

Accordingly, the "new evidence" or "mistake-in-fact" presented by Claimant was addressed by both judge Thomas and by the Board. To seek review of the Board's decision, Claimant should pursue his appellate rights in the Fifth Circuit as this Court is without authority to overturn issues decided by the Board. Nevertheless, there is no "new evidence" or newly realized "mistake-in-fact" in Claimant's modification request on which to base an award of compensation.

III (D) Conclusion

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[4] Judge Thomas also relied on the fact that "the majority of physicians who examined Claimant and/or reviewed medical records, concluded that there was insufficient evidence to support a diagnosis of pneumoconiosis." Numerical superiority, however, is not a valid basis to discredit opposing physicians. *See Woodward v. Director, OWCP*, 991 F.2d 314, 321 (9th Cir. 1993)(finding that using numerical superiority encourages a quest for numbers and illustrates little more than the disparity in the financial resources of the parties.). Judge Thomas also discredited Dr. Rasmussen on the basis that he relied on a *incorrect* smoking history, when in fact, Dr. Rasmussen had relied on a correct smoking history. Furthermore, Judge Thomas' reason for discrediting Dr. Rasmussen because the Dr. Rasmussen inferred that Claimant was continuously exposed to coal dust over eight years is not particularly persuasive since other physicians in the record also assume that Claimant had an adequate exposure period to develop pneumoconiosis.

[5] In this regard, I note that Dr. Rasmussen was not a B-reader in 1993 and that his x-ray interpretation would be entitled to less weight.

Claimant timely filed a Request for Modification as the request fell within the one-year time period after the Board issued its decision affirming Judge Thomas' decision. Likewise, Claimant timely filed a Request for a Formal Hearing because he mailed the request within thirty days after being served with the District Director's proposed decision. Claimant is not entitled to a modification of Judge Thomas's denial as no "new evidence" of pneumoconiosis was presented by Claimant, and the only "mistake-in-fact" was Claimant's smoking history which would not alter the opinion of Dr. Fino, because even the lowest history was enough to cause chronic obstructive bronchitis or emphysema, and smoking history was never even a consideration for Dr. Wiot in reviewing x-ray evidence. Additionally this "mistake-in-fact evidence was considered by the Board in rendering its decision approving Judge Thomas' denial of benefits.

IV. Order

Accordingly, I find no basis to modify the decision to deny Claimant's benefits under the Act. Claimant's request for Modification is **DENIED**.

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CLEMENT J. KENNINGTON
Administrative Law Judge